HAWAII STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
1177 Alakea Street, Suite 402 • Honolulu, HI 96813 • Phone: (808) 587-0788 • www.shpda.org
Kauai County Subarea Health Planning Council

Meeting Minutes
August 8, 2023
2:00 PM Hawaii Time

Virtual Zoom Meeting and Physical Location at the
Keoni Ana Building, 1177 Alakea Street, Suite 402

MEMBERS:	Jen Chahanovich, Jillian Kelekoma, Nicholas Pananganan
MEMBERS ABSENT:	None
GUESTS:	Nalani Pierce
SHPDA:	John “Jack” Lewin, Wendy Nihoa

ATTENDANCE RECORD OF APPOINTED MEMBERS

Date	9/16/21	11/18/21	1/20/22	3/17/22	6/20/22	8/18/22	2/14/23	3/14/23	6/13/23	8/8/23
Jen Chahanovich	X	O	O	X	X	X	O	X	X	X
Jillian Kelekoma*	X	X	X	O	X	X	X	X	X	X
Nicholas Pananganan**	O	X	X	O	X	X	X	X	X	X

Legend: X=Present; O=Absent; /=No Meeting
*-Chair, **-Vice Chair

TOPIC	DISCUSSION	ACTION
Call to Order	The meeting was called to order at 2:00 p.m. with J. Kelekoma, Chair, KCSAC presiding.	
Row Call/Introductions	Members, guest, and staff introduced themselves.	
Meeting Minutes	The minutes of the June 13, 2023 meeting was reviewed and unanimously approved.	
	Call for public testimony – none.	
Administrator's Report	The Administrator's Report was distributed and reviewed.	
State Health System Reform Planning Update	J. Lewin, SHPDA Administrator, provided an update. Referenced a document in draft form "Hawaii the Health State 2024", attached as "Attachment A". Highlighted initiatives focused on keiki, kupuna, and universal access. Continuing to meet with various leaders and stakeholders.	
	A brief discussion followed.	
	Call for public testimony – none.	
Presentation	A presentation on "Community Health Care Activities" was given by Nalani Pierce, Coach, Hui O Mana Ka Pu'uwai Canoe Club. A copy of the presentation is attached as "Attachment B".	
	A brief discussion followed the presentation.	
Election of Chair and Vice Chair	J. Kelekoma was nominated to serve year two of the two-year KCSAC Chair term. The vote in favor was unanimous.	
	N. Pananganan was nominated to serve year two of the two-year KCSAC Vice Chair term. The vote in favor was unanimous.	
	Call for public testimony – none.	
KCSAC Member Recruitment	W. Nihoa will be meeting with Boards and Commissions on the status of applications submitted. Currently no applications pending for KCSAC. The "SHPDA Council Nomination" form was previously disseminated to members and attached as "Attachment C". Members expressed continued difficulty recruiting new members.	

	Call for public testimony – none.	
Community Healthcare Needs Assessment Project	J. Kelekoma, Project Lead reported a draft survey is in progress. Will be finalizing before the next KCSAC meeting. The new fire recruits and the fall prevention program staff will be utilized to disseminate the survey. Plan is to report preliminary survey results at the next KCSAC meeting.	J. Kelekoma and W. Nihoa to finalize survey questionnaire.
	Call for public testimony – none.	
Announcements	W. Nihoa. Act 125 relating to the recording of public meetings will go into effect on October 1, 2023.	
	Act 165 relating to mandatory ethics training went into effect on January 1, 2023. Members were encouraged to complete the self-directed (online) training via the Hawaii State Ethics Commission website at Hawai‘i State Ethics Commission (hawaii.gov).	
Next Meeting/Agenda	October 10, 2023 @ 2:00 p.m.	
	Agenda Items: Community Healthcare Needs Assessment survey results; presentation from Kauai Vistors Bureau.	
Adjourn	The meeting was adjourned at 2:42 p.m.	

‘Hawaii the Health State 2025’; A Vision and Discussion Paper

John C (Jack) Lewin MD
Administrator, Hawaii State Health Planning and Development Agency (SHPDA),

Preface: *this outline is an early phase ‘proposal-in-development’ for discussion purposes only.*

While we as a nation have an outstanding record of global leadership in medical science, health technology and innovation, medical professional training, and clinical research, America has a problematic health care “non-system” as compared to other developed nations, characterized by excessive regulatory ,administrative and delivery system complexity; growing unaffordability for families, businesses, and government; unacceptable variation in outcomes despite numerous examples of high quality care; and growing stresses on recruiting and retaining sufficient health care professionals and staff now and for the future. Yet, we are spending nearly twice what other developed nations spend per capita. There are savings to be had, but they are hard to access. Given that health care costs are rapidly increasing beyond our current US spend totaling (with 50% public dollars) well over 4 trillion dollars in 2023, and currently projected to exceed seven trillion by 2030, it is remarkable that more public concern is not generating urgent political demand for action. That will surely manifest soon as the rising federal and state costs of Medicare, Medicaid, the VA, the military, Indian Health Services, workers compensation, CHIP, and generous federal tax forgiveness for employer sponsored private coverage coalesce to form a monster that is vampirizing other sectors of the economy.

Hawaii has a remarkable tradition of health system reform innovation. Plantation workers in Hawaii had a tradition of receiving health care long before it became available for US workers after WW II. It was maybe not the best care, although generally adequate, but such care was totally unavailable for agricultural workers anywhere else in the world, including in the mainland USA. The Prepaid Health Care Act (HPHCA), passed in 1974, but vacated years later before enactment by the Supreme Court for violating the Employee Retirement Income and Security Act (ERISA) of 1974, has assured good health care for nearly ALL (except part-time) workers and their families in Hawaii after a Hawaii “ERISA exemption” was passed by Congress in the 1980s. The law performs well for Hawaii until today. It is widely felt in Washington that ERISA, which requires an exemption from Congress before states or municipalities can mandate employee health or retirement benefits from businesses, was passed just months after the HPHCA in 1974 to prevent other states from copying Hawaii. Then again, in 1989, Hawaii passed the State Health Insurance Plan (SHIP), which moved the state very much closer to universal insurance coverage by offering low-cost coverage for part-time workers, mom-and-pop business owners, independent contractors, workers paid by commission like realtors, and for students, and others not covered by the HPHCA, Medicare, or Medicaid. These were first-in-the-nation innovations! Hillary and Bill Clinton tried to use the Hawaii innovations as the foundation of their plan, and California passed a version of the PHPCA. That would have changed everything in the US. But, unfortunately Arnold Schwarzenegger, at the insistence of his party, led a ballot initiative to narrowly by ½% kill the California bill before implementation. But, all said, Hawaii’s innovation was noticed nationally.

So, from a high point of nearly 97% insured after the above innovations in 1980s and 1990s, Hawaii has slipped somewhat backwards. SHIP got folded into Medicaid-Quest, the premiums became too expensive, and folks dropped out. Many of those are again uninsured today, although Hawaii still has an impressive 94% insured rate. That said, why accept 6% uninsured, many more “underinsured,” and the sharp rises in out-of-pocket costs, even in Medicare? Doctors, hospitals, and patients need “prior authorization” before a necessary test, drug, or procedure can be provided. And there are many other bureaucratic, administrative, and cost frustrations that patients, doctors, hospitals, and even insurers face today.

Unfortunately, Congress is now too divided to tackle these issues. Senator Sanders, in Ted Kennedy’s footsteps, has 30% of America behind his “Medicare for All” concept. But it will not become law. The path toward guaranteeing universal coverage and health system reform must rely now on state leadership.

Principles of Value in Considering a Hawaii Health System Reform 2025 Strategy: An Incomplete List

1. The vision must include and engage all stakeholders, importantly including Native Hawaiians, in its collaborative development.

2. The strategy must focus on reallocation of unnecessary and wasteful spending for its financing; but Hawaii must also receive its fair share of federal support (Medicare, Medicaid, FMAP, GPCI).

3. *Prevention* is the key to achieving a more efficient, effective health care system. Working with DOH, this must include 100% access to proven prevention-related health care services including vaccines and prevention-related disease screening and treatment, without financial disincentives; 100% access to screening for early diagnosis for preventable and serious illness and for effective chronic disease management*;* also major emphasis with financial clinician *incentives* on prevention of unnecessary ED visits, hospitalizations, and re-hospitalizations.

4. The primary focus of all services must be first on the most disenfranchised populations.

5. Improving access to and quality of care for Keiki and Kupuna are appropriate initial foci, given these are important bookend populations of Hawaii's society, culture, and future.

6. While excessive profiteering is a growing concern across all of US health care, a critical focus in Hawaii must be on increasing adequate resources and reimbursement for recruiting and retaining the highest quality physicians, nurses, other clinicians, social workers, and caregivers in the face of high housing and costs of living here.

7. Excessive regulatory and administrative costs, waste, and complexity in US health care must be streamlined and eliminated in Hawaii's future. But investing in new administrative costs should rightly focus on accurate population outcomes monitoring and systematic improvement.

8. New financing models that emphasize value-based reimbursement and incentives for improving outcomes at lower costs must be considered, tested, and implemented.

9. Given the rapidly aging population (Hawaii is the #1 state in longevity), and the fact that there will never be enough caregivers to meet the needs of the population in the future, new technologies must be included to leverage caregivers to effectively reach more patients in a high-tech, but also high-touch future delivery system approach.

10. The state must more effectively partner with the federal government (Medicare and Medicaid, the VA, the Hawaiian Trust, etc.) to maximize federal funding (Medicare benchmark, Medicaid, FMAP) to develop innovative approaches, waivers, and include *social determinants of health!!*

11. The most modern technology, telehealth, and care delivery systems must be cost-effectively available for Hawaii's 1.4 million citizens and 8 million annual visitors. We are not a backwater.

12. For patients, providers, or observers of health care in Hawaii's future, the concepts of Aloha, Ohana, Malama, Laulima, and Ho'ihi (respect) should seem appropriate to their experience.

Big Seven Potential Short and Long-Term Priorities for the "Hawaii the Health State 2025" Vision -- A Work in Progress

Note: Simplicity is key to a successful health policy strategy proposal. The following outline appears complex but is simply an incomplete list of potential options to be considered, modified, and prioritized by a Governor-appointed, legislatively confirmed "Hawaii the Health State 2024" Task Force of possibly 11-21 appointees of consumer and health care stakeholders. It is not a plan.

1. **Keiki Care Initiative** (short term - sub-Committee of SHPDA PDC and DHS to be engaged)
    - Identify and find financing via MedQuest/CMS to provide universal kid (0-18) health insurance coverage.
    - Note: Keiki care is relatively inexpensive and could be included in Quest waiver update or CHIP. *Modest planning budget may be needed for FY 2024 in DHS.*
    - Research and identification of gaps (consider help of DHS Medicaid/Quest, HAH, HHSC, Kapiolani, pediatricians, FQHCs, etc.) Include SDOH (social determinants of health)
    - Oral care for Keiki is lacking – CHIP can help as can fed HRSA funding, BUT: we don't have enough dentists. Expanding dental care in FQHCs and pediatric offices is an option?
    - As longer-term possibility, consider possible early child accountable care organization (ACO) federally subsidized MedQuest plan with Kapiolani, Castle, HHSC, pediatricians, NICU docs, and family medicine. Could include expanded prenatal care services, given Hawaii's 50th (worst) ranking in the US for delayed prenatal care until third trimester.
    - Ultimately, the biggest health care boost for KEIKI in Hawaii would entail getting universal childcare for preschool keiki 3-5 years (cost is significant but huge boost to economy as well).

2. **Kupuna Care Initiative** (short term < 1 year – sub-Committee of SHPDA PDC to be engaged with participation of EOA, AARP HI, palliative care (Hui Pohala), DHS-Medicaid/Quest, HAH, HMSA, KP, Aloha Care, home care agencies, hospice, Papa Ola Lokahi, and insurers). *Planning budget needed for 2024*
    - Working with DHS/MedQuest in waiver update, develop new programs and new care delivery models to keep Kupuna at home vs. nursing homes and LTC placement (factor in social determinants of health – SDOH)
    - Expand use remote patient monitoring (RPM), chronic care management (CCM) existing Medicare funding, and Medicare Advantage plans with SDOH $$$ options to implement
    - Involve DHS/MedQuest with dual eligible Medi-Medi patients.
    - Utilize pay-for well-care short visits and for individual itemized services to reach more patients more cost effectively
    - Also implement "Acute care, hospital-at-home" care initiatives as well
    - Reallocate savings from LTC/nursing home Medicaid funding to home care services (current nursing home/LTC costs are > $100K/yr. - and therefore providing $50K of advanced home care services/yr. would generate $50K of savings. Modified CMS waiver?)
    - Employ extensive use of advanced telemedicine services to facilitate physician, nurse, and other clinician care at home. When seniors are not tech savvy, such services and physician visits can be facilitated through onsite health navigators or home health clinicians.

3. **Recruitment and retention of sufficient physicians, nurses, social workers, other clinicians, and caregivers for Hawaii Initiative**: (short- and long-term goal needing engagement of physician and professional organizations, Legislature, and others, including SHPDA PDC (Planning/Development Committee). *Planning budget needed for 2024.*

- Full utilization of currently funded loan forgiveness funding for recruitment, especially for shortage areas. Reallocate unused loan forgiveness funds to other recruitment/retention options as possible.
- Consider launching new CMS "ACO Reach" CMS plans for Medicare (these offer physicians management of both Part A and Part B funding = 80% of total premium). ACO Reach powerfully incentivizes better preventive care and reduced ED and hospital admission and re-admission costs, and payment incentives.
- Renegotiate Medicare flawed payment patient state benchmark payments (currently $12K/yr./beneficiary average in US, but only $9K/yr./beneficiary in Hawaii) to account for Hawaii COL and real estate costs (a longer-term but *essential* strategy).
- Employ telemedicine services extensively where clinically appropriate
- Ensure for physicians/clinicians engaged in value-based reimbursement models that real-time access to claims, diagnosis code, HCC (CMS hierarchical condition categories), SDOH, and equity related data is available to manage patients effectively (see also the need for a Hawaii "comprehensive statewide clinical health data system" under Item 5 below to accomplish this)

4. **Prevention as the 'power' strategy behind outcomes improvement and cost containment:** (Prevention is obviously underfunded, under-emphasized, and under-reimbursed for patients and providers). Hawaii must lead the nation in systematically employing primary and secondary disease screening and prevention strategies in care delivery, including applications of genetic testing for early detection and treatment of inheritable disease. Further, a huge prevention benefit will be realized from reducing health care spending and costs from prevention of unnecessary ED visits, hospitalizations, re-hospitalizations, and disease complications.

5. **Hawaii Health Status Monitoring and Population Health Initiative**: (short and long-term strategy) *Modest planning budget needed for 2024.*

- Short term:
  - Add resources as indicated to increase analytics capabilities from Hawaii's existing All Payer Claims Database (APCD) to improve health status and population-based monitoring via SHPDA, DHS, UH, the Hawaii HIE, and other collaborators. Collaborate with HAH discharge and LTC existing data sources as well. Include behavioral health and mental health data and population status
  - Increase privacy-assured sharing of outcomes shortcomings and progress with hospitals physicians, and other providers to enhance population-based health status improvement, again including behavioral health and substance abuse.
- Longer-term:
  - Develop a "comprehensive statewide clinical health data system" in Hawaii capable of tracking as close to 100% of comprehensive personal health data, with personal privacy protections in place, for both convenience and clinical benefit of patients (accessing their own data) and of clinicians and health systems granted access by patients to such data. Sources of such data are EHRs,

claims data, lab and pharmacy data, radiologic images, health information exchange data, including mainland sources of data. Patients will opt-in to the system through their physician, hospital, or insurer, and can opt-out at any point. From a public health point of view, de-identified data from all such sources can be used to monitor population health and disease outbreaks more effectively.

- Seek means to include physician and other outpatient data sources including Hawaii's FQHCs to increase awareness of prevention, disease management, behavioral health, and population-based outcomes related to outpatient care
- Seek means to integrate clinical data sources from national specialty society registries (such as National Cardiovascular Data Registries, etc.), and CDC, NIH, and other clinical data sources.
- Finally, integration systems that can access and integrate social services data, behavioral health data and other clinical data are needed to enable SDOH to improve clinical and health outcomes.

6. **Statewide Regulatory and Administrative Simplification and Cost Reform Initiative** (a short- and long-term strategy – *planning budget needed for 2024 Legislature*)
    - Short term:
        - Statewide "prior authorization" (PA) automation reform: this can be a quick win! Cost would be approx. $5M in 2024 ($3M one-time spending and $2M per year ongoing). PA costs physicians, hospitals, and insurers millions per year; hassles everybody; and delays essential imaging, medication, and procedural care for patients, often endangering outcomes. Hawaii should be first to do this.
        - Statewide Quest formulary simplification reform: also, a potential quick win. Cost is minimal. Each of 5 Quest plans has a different formulary, complicating work for physicians, clinicians, pharmacists, and hospitals. Strategy: convene plans a negotiate a common formulary.
        - More extensive formulary integration and simplification should also be undertaken for privately insured, FQHC (HPCA), and Medicare/Medicare Advantage patient populations.
    - Long Term: Develop a coordinated strategy with CMS (Medicare and Medicaid, DHS Hawaii, HMSA, HHSC, Aloha Care, and other payers to simplify and make as consistent as possible regulatory and administrative rules, reporting, payment systems, formularies, quality of care monitoring, and other interfaces and IT systems for physicians, hospitals, and other providers. Planning budget for legislature TBD.
        - The goal is to reduce costs, improve efficiency and collaboration for all participants. The specifics of this goal will need be developed over the next year as more relevant data and high-level conversations lead to workable approaches for all health care participants.
        - HMSA, Aloha Care, other payers (including United and Humana) and DHS/MedQuest/CMS Medicare and Medicaid are the key payer-side participants in this goal. However, Queens MC, HPH, HHSC, HMA, and other provider organizations will also be essential participants in solution crafting.

5. **<u>Hawaii Universal Access at Affordable Cost Initiative</u>** (short- and long-term strategies)
Health Access, health equity, and health care costs are inextricably entwined. Health care costs are rising rapidly as a percent of US GDP, and are also becoming increasingly unaffordable for families, businesses, and government. Universal access and equity require <u>affordability</u> to be realized. Focusing on prevention, team-based primary care, reduction of administrative and regulatory waste and costs, making behavioral health a more effective aspect of primary care, and systematically reducing unnecessary ED visits and hospitalizations, as previously stated, will be essential to achieving affordability. Include Papa Ola Lokahi early in the brainstorming. But in addition:
   - Short-term:
      - Beginning with Keiki universal access, and Kupuna expanded access to advanced home care services, consider how to expand Medicaid (or CHIP) access to cover all keiki 0-18 as a first step. Working with MedQUEST/CMS to get this done.
      - Explore access to additional benefits for special populations, such as an ACO or special coverage plan for high-risk prenatal care and high-risk children 0-3 --- more to be discussed later but *include school health services!* Include DOE's "community care" concept of accessing family health services at schools!
   - Long-term:
      - Develop over next 2 years a strategy for achieving full universal access to defined benefits per age from birth to end-of-life by 2024 or 2025 for all citizens in Hawaii, working with the aforementioned multiple stakeholders, but importantly including CMS Medicaid, DHS/MedQuest, FQHCs, all payers, the provider community, and consumer stakeholders with financing options for possible implementation in 2025 – much more to be discussed after significant research, data analysis, actuarial research and other background work can first be conducted. *Planning budget needs to be developed for 2024 legislature.*
      - Strictly monitor against any further "tiering" of health care based on income.
      - Keep clear in mind that universal access will be fully dependent on achieving in parallel a robust prevention focus, regulatory and administrative costs containment and simplification, behavioral health services enhancement, and federal partnership. Assuring Hawaii receives its fair share of federal resources; and that new value-based payment and reimbursement models (better outcomes at lower costs). Much more discussion and deliberation on this initiative will be needed. SDOH must be centrally factored in!
      - A foundation of team-based primary care that includes social workers, health navigators and which is community based will be essential to success.
      - Also carefully consider other state experiments in progress, such as Colorado's Public Option, and new potential new care financing options, including a possible CMS-Hawaii *Medicare Advantage (MA) for All* model (creating a public option with MA to allow individuals 0-65 to buy in and to make the option a choice for employer-sponsored care), and finally a statewide ACO model.
      - Engage DHS/MedQUEST, DOH, HMSA, Aloha Care, Queen's, HPH, HHSC, EUTF (HI Employer-Union Health Benefits Trust Fund), HAH, HMA, HPCA (HI Primary Care Ass'n), HIPA (Hawaii Independent Physicians Ass'n), HNA, Papa Ola Lokahi, Hui Pohala, and other providers in the brainstorming process with the Governor, Legislature, and the federal DHHS/CMS leading to an affordable and

implementable future of universal access to equitable, high-quality, value-based, prevention-focused health care for all Hawaii citizens.

Hui O Mana Ka Pu‘uwai

Pu‘uwai Canoe Club Leadership

Pu‘uwai Canoe Club organization is structured to meet the responsibilities of stewardship. The Board of Directors consists of five individuals who are elected for a ten-year term. Additionally, there is a slate of officers who are elected yearly.

The Board of Directors possesses the skill sets necessary for successful management and growth.

Responsibilities

The Board of Directors is responsible for overseeing the management and growth of the Pu‘uwai Canoe Club.

Embedded within the elected officers is a Grant Committee whose sole responsibility is to apply for, track, manage and provide transparency for all grant funding.

There also exists a fundraising committee whose responsibility is to organize and manage two to three major fundraising events each year.

Wailua River Valley (Ahupuaʻa) in Hawaiian History and Culture

The Wailua River Valley (Ahupuaʻa) is a significant cultural location on the island of Kauaʻi, with a rich history in pre-contact Hawaiʻi. It was not only a thriving community of makaʻainana, but also the hub of the island kingdom under the reign of Kaumualiʻi. Additionally, Wailua was the embarkation and disembarkation point for most inter-island waʻa kaulua (voyaging canoe).

The cultural significance of Puʻuwai Canoe Club in this location is profound. As a fusion of sport and cultural practice, the stewardship and future vision of a center will give Puʻuwai the opportunity to contribute to the local community, as well as to visitors, by educating and enhancing their experience of Hawaiian practices, protocols, arts & crafts. The goal is to promote the significance of the waʻa and it's role in Hawaiian history and culture.

Preserving Traditional Hawaiian Practices

Our club members and board members are well-versed as Hawaiian artisans and practitioners, which allows us to develop programs that focus on the cultural significance of the location. Our goal is to educate and enhance the local and visitor experience as it relates to the wa‘a and the significance of the canoe in Hawaiian history and culture.




Programs

- Lei making
- Lauhala weaving
- Kalo preparation
- Fishnet making
- Sailing canoe

Athletic Coaching Staff

Pu'uwai has a team of exceptional athletic coaches who are dedicated to developing athletes at all levels. Each coach has at least 30 years of experience in their respective sport, from keiki development to senior athletic management.

Women's Coach: 30+ Years of Experience

Expertise in coaching female athletes at all levels.

Men's Coach: 30+ Years of Experience

Expertise in coaching male athletes at all levels.

Keiki Coach: 30+ Years of Experience

Expertise in developing young athletes and fostering a love for the sport.

Kapa‘a High School Coach: 30+ Years of Experience

Expertise in coaching high school athletes and preparing them for collegiate-level competition.

The coaches at Pu'uwai embody the Hawaiian value of 'ohana in everything they teach, creating a cohesive and sustainable organization. The Board and Officers have taken on their duties so that these coaches can focus solely on what they do best, developing exceptional athletes and laying a foundation of health and wellness in their lives.

Future Aquatic Center

Pu‘uwai Canoe Club envisions the Wailua River as a training zone and playground for various watersports, including competitive canoe sailing, Olympic sprint kayaking, sculling, and rowing. Our membership includes world-class coaches in these disciplines, and our venue is perfectly suited for their training and development.

In addition to providing top-notch facilities and equipment, we also offer strength development and conditioning programs to help athletes reach their full potential. And unlike other exclusive clubs, we are committed to being inclusive, particularly to our community keiki. Our goal is to be keiki-centric with adult supervision, creating a welcoming and supportive environment for young athletes to thrive.

Pu'uwai Canoe Club and Kauai County Health Planning Council Initiatives

Our canoe club initiatives align with the Kauai County Health Planning Council's mission to promote health education, wellness and healthy living in the community. By building partnerships and collaborations, we can work together to achieve our shared goals.

Collaborative Initiatives

1. Health and Wellness Workshops: Our canoe club can host health and wellness workshops to educate our members and the community on healthy living practices and what services are available to the community.

2. Community Events: We can participate in community events suggested by various health organizations such as health fairs and fitness challenges, to promote healthy living and build awareness about our canoe club.

3. Prevention and Early Intervention: By creating a safe space for our keiki to thrive we can increase community education and awareness of drug and alcohol abuse, as well as chronic diseases.

Pu‘uwai Prayer

Thank you Heavenly Father for taking care of us.

Guide our canoes over the calm sea.

Strengthen and protect us.

And bless our club, Hui O Mana Ka Pu‘uwai, until we meet again.

Amen

Mahalo Ke Akua no ka mālama ana mai iā mākou.

E kia‘i ‘oe i nā wa‘a maluna o ke kai mālie.

E ho‘oikaika a ho‘omalu iā kākou.

E ho‘opōmaika‘i i ko mākou Hui O Mana Ka Pu‘uwai a i ka hui hou .

‘Amene ‘Amene ‘Amene.

Mahalo

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
Council/Committee/Task Force Nomination Form

Nominator's Name: _____

Nominee Information:
Name: _____

Title (if applicable): _____

Affiliation (if applicable) _____

Email Address: _____

Phone Number(s): _____

Other Contact Info: _____

Indicate the Council(s)/Committee(s) for which you are making this nomination:

☐ Statewide Health Coordinating Council (SHCC)*
☐ Tri-Isle Subarea Health Planning Council*
☐ Windward Subarea Health Planning Council*
☐ Hawaii County Subarea Health Planning Council*
☐ Kauai County Subareas Health Planning Council*
☐ West Oahu Subarea Health Planning Council*
☐ Honolulu Subarea Health Planning Council*

☐ Statewide Health Coordinating Council Plan Development Committee (PDC)**

☐ PDC Subcommittees:
- ☐ Acute Care Service Technology***
- ☐ Long Term Care Services***
- ☐ Primary Care Services***
- ☐ Health Disparities***
- ☐ Data and Service Gap Areas***
- ☐ Behavior Health***
- ☐ Substance Use Disorder***
- ☐ Workforce***

**Governor Appointed Position*
***SHCC Appointed Position*
****PDC Appointed Position*

Why the nominee would be a good candidate for the position(s) indicated above (use space on back if needed):

_____
_____
_____
_____

Is the nominee aware of this nomination? ☐ Yes ☐ No

Has the nominee expressed interest? ☐ Yes ☐ No

Thank you

For office use:
☐ Confirmed Interest _____
☐ Not interested at this time.
☐ Info on Application Process Provided _____
☐ Application Submitted on _____
Notes: